WEBINAR

HOW TO DELIVER HIVST IN A SUSTAINABLE MANNER TO INCREASE TESTING COVERAGE AMONG PRIORITY POPULATIONS

PART 3/6: EXPERIENCES AND LESSONS LEARNED FROM STAR

Thursday, August 27 2020
9:00am EST
3:00pm UTC/GMT+2

Unitaid
HIV SELF-TESTING AFRICA INITIATIVE

atlas
From proof of concept to targeted, sustainable approaches of community-based and community-led HIVST

Beyond 95-95-95

Prof Liz Corbett, LSHTM for STAR Consortium
STAR implementation research consortium

UNITAID
STAR Project
STAR Initiative

WHO
Policy & Regulatory

Population Services International (PSI)
Implement’n & Market

London School
Research Consortium

PSI-Malawi

PSI-Zimbabwe

SFH-Zambia

SFH-S Africa
Wits, CHAI, MoH

Swaziland & Lesotho

MLW Malawi

CeSSHAR
Zimbabwe

ZAMBART
Zambia

Africa Health Research Inst

UCL

Liverpool
STM

Country research & implementation teams
- 8 Cluster-randomised trials in 4 countries 2016-2020
- Findings from 4 CRTs summarised here
Progress towards 95-95-95

Fast-Track Targets

by 2020

90-90-90
HIV treatment

500,000
New HIV infections or fewer

by 2030

95-95-95
HIV treatment

200,000
New HIV infections or fewer

ZERO
Discrimination

ZERO
Discrimination

Undiagnosed HIV, as % all PLHIV, globally: “First 95”

- 2005: 90%
- 2015: 45%
- 2019: 19%
- 2030 UNAIDS target: 5%

UNAIDS Gap Report 2020
Progress towards 95-95-95

- Rapid progress: however
  - Testing still the biggest gap in care cascades
- Diversified and decentralized services
  - Self-testing an important “COVID-robust” innovation
  - Key effective and affordable models

UNAIDS Gap Report 2020
3 Community-based & 1 community-led trial
Malawi, Zambia, Zimbabwe 2016-18 (CBD), Malawi community-led 2018-19

• **Community-based**
  - Paid kit distributors serving own community
  - lay “community-based distribution (CBD) agents”

• **Community-led**
  - Provide commodities, participatory workshops & kit training
  - Communities responsible for kits distribution and support
  - *Better or same outcomes for same or lower costs?*

• Costed cluster-randomised trials (CRTs): rural/periurban

• Over-arching aim: **recent testing, linkage to care and prevention**

*Sibanda et al, Neuman et al, Indravudh et al manuscripts submitted
Mangenah JIAS 2019 (costs)
<table>
<thead>
<tr>
<th>Approach &amp; duration</th>
<th>Malawi: Com-led HIVST vs SOC</th>
<th>Malawi: CB HIVST vs SOC</th>
<th>Zambia: CB HIVST vs SOC</th>
<th>Zimbabwe: CB Both arms HIVST</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Door-to-door-PLUS (community plan) 1-2 week campaign</td>
<td>Door-to-door</td>
<td>Implementer plan</td>
<td>Door-to-door 4-6 week campaign</td>
</tr>
<tr>
<td>Comparison arm</td>
<td>SOC</td>
<td>SOC</td>
<td>SOC</td>
<td>Distributor Remuneration</td>
</tr>
<tr>
<td>Distributor pay</td>
<td>$10 per lead team member</td>
<td>Fixed + US$ 0.15 per kit</td>
<td>Fixed + US$ 0.56 per kit</td>
<td>Fixed +/- US$0.2/client linked</td>
</tr>
<tr>
<td>distributed</td>
<td>Cost per kit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Randomisation</td>
<td>Clinic catchment area (constrained)</td>
<td>Clinic catchment area (constrained)</td>
<td>Clinic catchment area (pair matched)</td>
<td>Ward (constrained)</td>
</tr>
<tr>
<td>unit and design</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Number of clusters</td>
<td>30</td>
<td>22</td>
<td>12</td>
<td>38</td>
</tr>
<tr>
<td>Primary outcome</td>
<td>Adolescent testing (ever)</td>
<td>Recent testing (12 mo)</td>
<td>Recent testing (12 mo)</td>
<td>Linkage to any service</td>
</tr>
<tr>
<td>Secondary outcome</td>
<td>ART initiations using routine facility data</td>
<td>ART initiations using routine facility data</td>
<td>ART initiations using routine facility data</td>
<td>ART initiations (non-randomised)</td>
</tr>
</tbody>
</table>
Coverage of HIVST at population level
- household surveys ~5,000 participants per country

Endline survey respondents - % who used HIVST kit

Community-based distribution
1. Malawi: 42.5%
2. Zambia: 26.3%
3. Zimbabwe: 50.2%

Community-led distribution
4. Malawi: 74.5%
5. Zimbabwe: unblinded but not yet presented

See also Urban HIVST trial in Malawi: MacPherson JAMA 2014 and Choko PLoS Med 2015
Is recent testing increased at population level?

- yes in 2 of 3 studies with standard of care arm

Tested for HIV in the last 12 months: household surveys

NB – between 2018 and 2019 in Malawi
- HIV testing in previous 12 months increased in SOC arm
- Thus RR lower despite high HIVST coverage with CL intervention
Zambia – implementer-led multiple strategy

CBD agent seen in community

Intervention cluster for pair 1: GPS coordinates of HIVST kit distribution in a block

CBD agent visited household
How do costs of HIVST compare with routine HTS?

<table>
<thead>
<tr>
<th></th>
<th>Routine clinic HTS cost per person</th>
<th>HIVST CBDA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cost per person tested</td>
<td>Tested +ve</td>
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<tr>
<td>Malawi</td>
<td>5.03</td>
<td>79.58</td>
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<tr>
<td></td>
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<td>8.15</td>
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<td>Zambia</td>
<td>4.24</td>
<td>73.63</td>
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<td>16.42</td>
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<tr>
<td>Zimbabwe</td>
<td>8.79</td>
<td>178.92</td>
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<td>13.79</td>
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<tr>
<td>Number of sites</td>
<td>54</td>
<td>71</td>
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</tbody>
</table>

Mangenah JIAS 2019
## Economies of scale: CB HIVST distribution

<table>
<thead>
<tr>
<th>Country (sites)</th>
<th>Ave. cost</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malawi (11)</td>
<td>$ 8.15</td>
<td>$ 7.20</td>
<td>$ 17.04</td>
</tr>
<tr>
<td>Zambia (16)</td>
<td>$ 16.42</td>
<td>$ 7.03</td>
<td>$ 50.01</td>
</tr>
<tr>
<td>Zimbabwe (60)</td>
<td>$ 13.79</td>
<td>$ 7.90</td>
<td>$ 54.44</td>
</tr>
</tbody>
</table>

**Diagram:**
- **X-axis:** Number of Kits distributed per site
- **Y-axis:** Cost per Kit
- **Legend:**
  - Malawi
  - Zambia
  - Zimbabwe

*Source:* Mangenah JIAS 2019
Effect of community HIVST on ART uptake

2 designs: both will tend to underestimate true effect

**Malawi / Zambia**: Clinic catchment area
- *Only measuring ART uptake at one central clinic*

**Zimbabwe**: each ART clinic in study districts classified as “exposed/unexposed” to HIVST

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**HIVST cluster**

- ART
- Remote villages
- HIVST

**SOC cluster**

- ART
- Reproductive health only villages

**District**

- ART No ST
- ART
- HIVST
- ART no ST
- PSI Outreach Wards
- HIVST +/- distributor linkage incentive
- ART No ST
- ART
- HIVST

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**Notes**

- Malawi / Zambia: Clinic catchment area
- Only measuring ART uptake at one central clinic
- Zimbabwe: each ART clinic in study districts classified as “exposed/unexposed” to HIVST
- 2 designs: both will tend to underestimate true effect
Is demand for ART increased at population level?
- yes in the 2 “campaign style” delivery models

HIVST vs SOC clusters: new ART initiations after campaign
Data captured from only one clinic per cluster

Malawi Com-led
Zimbabwe Com-based

ART within 3 months of HIVST
ART >3 months

Risk ratio (95% CI)

Time trends in ART initiation relative to HIVST campaign

Zimbabwe: Difference-in-differences
Whole clinics assigned HIVST+/-

40 ART clinics with HIVST in catchment area
124 clinics with no HIVST in catchment area

HIVST campaign period

Neuman meta-analysis in prep
Social harms

• All approaches well received

• As with all HIV testing, some participants felt pressured / unable to refuse testing
  • 5% Zim Endline adolescent participants
  • 0.5% (CB) and 0.4% (CL) “forced to self-test” in Malawi Endline surveys by partner or family etc

• Low prevalence of serious social harms
  • 1 report in >80,000 kits distributed in Zimbabwe
  • 2 reports in 80,000 kits distributed in Malawi
Discussion and Conclusions

- 4 cluster-randomised trials evaluating implementation of community-wide HIVST
  - Strong evidence for impact and costs

- Community-based HIVST can **rapidly increase coverage**, including men and adolescents
  - Safe, effective, acceptable, desired, and low cost

- To maximise **measurable health impact** of HIVST
  - Door-to-door most reliable for local coverage
  - Campaigns produce clearest peak in ART demand
  - Target high burden communities or sub-groups
  - Include linkage strategy

- Community-led: “Better outcomes at similar or lower cost’’?
  - Malawi CL had **lowest distribution costs** and **highest coverage**
  - Preferred by PSI-Malawi for subsequent implementation

- Policy makers could target communities with HIVST campaigns
  - Once-off or **periodic (e.g. 5 yearly) campaigns**
  - Remote rural or urban slum communities with high HIV or low testing
  - Combine with other distributions (e.g. bednets) for economies of scope

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**HIVST to maintain 1st 90 in Zimbabwe**

[Graph showing proportion over time with lines for different scenarios]

Cambriano et al JIAS 2019: Slide courtesy of VC
WHO 2020 HIVST Guidelines
STAR team

- Researchers and implementers from Malawi, Zambia, and Zimbabwe
- Economics Network
- Quantitative and Epi Research Network
- Qualitative Research Network
- Communities, Ministries of Health and District Health teams

Website: [http://Hivstar.lshtm.ac.uk](http://Hivstar.lshtm.ac.uk)
WEBINAR

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 UNITAID

 Innovation in Global Health

 HIV SELF-TESTING AFRICA INITIATIVE

 R atlas

 Save: art and sex

 Health

 Science

 Rights
Building sustainable models of HIV Self Testing distribution through workplaces in collaboration with the ILO

Afsar Syed Mohammad
Senior Technical Specialist
Gender Equality, Diversity and ILOAIDS
ILO Geneva, Switzerland

Webinar: How to deliver HIVST in a sustainable manner to increase testing coverage among priority populations, experiences and lessons learned from STAR, 27 August 2020
Piloted HIV ST in Zimbabwe, South Africa and Zambia in 2019. ILO is part of the Unitaid’s STAR Project in seven countries to develop sustainable workplace models of HIVST.
Self Testing integrated into VCT@WORK

- Rights-based approach
- Strategic partnerships
- Multi-disease testing
- Advocacy and Communication
- Monitoring and Evaluation

VCT@WORK
A social media campaign

KNOW YOUR HIV STATUS
Early testing saves lives. Keeps you healthy and productive.
HIV self testing is highly appreciated. Good for those who are reluctant to test at the clinic. A worthwhile exercise!

A company’s peer educator, Zimbabwe
Key elements of the ILO’s model

• Adoption of a sectoral approach.

• Integration of HIV ST into existing workplace policy and programmes

• Focussing on hard-to-reach populations/men at risk.

• Use of existing financial and human resources
Example 1: HIV ST in the workplace in South Africa

- ILO is part of the Technical Working Group on HIV Self-Screening
- Focus on selected sectors
- Engaging a service provider working on HIV ST
  - Partnership with Re-Action.
- Facilitate partnerships between government departments, employers’, workers’ and their organizations
Critical Enablers

- Getting commitment of the management
- **Innovation**: HIV-Selfie as a point of engagement and the ability to take HIVST kits for partners
- Collaboration with the networks of PLHIV and Trade Unions
- Facilitate **linkage to care** through communication with peer educators and reference cards for medical services.
• Over 50,000 HIV ST kits distributed.

• Nine out of 11 sectors had more males receiving HIV Self-Test kits: **62% recipients were males.**

• The majority of those tested were people who were tested more than 12 months ago.

• 4,617 were randomly selected for follow up.
• 99% of these employees agreed to share their test results. 148 had a reactive HIVST result (3.3%)
Example 2: HIV ST at workplace in Zimbabwe

Implemented in a public private partnership mode.

Ministry of Health & Child Care, PSI, WHO, ILO, NAC

Started with a training of 10 companies in May 2019. Now, 20 companies on board.

“...If we all work together, if we all are accountable and if we leave no one behind, we will end AIDS. Workplaces will help us close the HIV testing gaps, particularly amongst men. I welcome collaboration with the ILO in initiating HIV self-testing in ten companies in Zimbabwe.”

Dr Owen Mugurungi
Director, AIDS & TB Unit,
Ministry of Health and Child Care
Zimbabwe
Training Content

- Basics of HIV and importance of early testing
- Overview of HIV ST and it’s implementation
- Demand generation, behaviour change communication and counselling
- Implementing HIV ST within a human rights framework
- The role of workplace peer educators
- Record keeping and reporting
- An agreed plan of action to implement HIV ST in selected workplaces.
Post training support

- Sensitization and testing of senior executives
- Training of 230 peer educators
- Training of medical management – doctors, nurses and general staff
- Training of workers committee
- Joint visits of MOH, PSI and ILO
Lessons learned

• HIV self-testing very well received by workers

  The ability to take HIV kits for partners was reported to result in opening the communication channels around HIV and in that way improved trust - South Africa

• More men were reached than women in all the three indicators: in usage, in showing reactive results and in taking the confirmatory tests

• Peer educators played a key role

• MOH need to create space for reports from workplaces in their national systems

• Technical support and regular follow up are important factors
Lessons learned

- Advocacy with management is key
- Develop management-specific messages
- Trade unions play an effective role

Management a bit sceptical, though staff welcomed the self test kits.

- A company’s focal point, Zimbabwe
The potential impact of HIV self testing at workplaces

- Reduces the HIV testing gaps amongst men at risk
- Tests those who had never tested or those who do not test too often
- Reduces the opportunity cost of testing for workers. Gives workers a choice.
- Cost-effective: potential of companies to pay for test kits and coverage in public and private health insurance
- Sustainable, if integrated within existing policy and programmes

Advancing social justice, promoting decent work
How is the HIV ST workplace model more sustainable?

• A significant part of the programme can be internally funded.

• It uses the existing structures in workplaces: Occupational Safety and Health, Corporate Social Responsibility; Wellness approach of companies etc.

• It creates internal capacities and builds it as a regular workplace policy/programme.

• It uses staff’s time and existing training and communication channels.

• It has the potential to cover hard to reach (contractual, migrants, supply chain workers and those in geographically remote workplaces) at a much lesser cost.

• It fosters public-private partnerships.
Different models of delivering HIVST through workplaces

• A company-led model with ILO’s TA, and test kits provided by MOH/project

• HIVST in the catchment areas of company – A PPP approach implemented under the CSR policy of the company.

• A trade-union led model in a sector like construction, transport etc.

• A CSO-led model for workers in the informal sector implemented in partnership with industry association, unions and MOH
Collaboration under STAR

- Reach men at risk and identified populations at country level.
- Participation in stakeholders’ consultations to present the ILO’s approach and lessons.
- Stakeholders’ consultations, advocacy and mobilization of partners from the world of work.
- Mapping of workplaces in regions prioritized for HIV ST under STAR.
- Developing sustainable models in the formal sector, informal sector and industrial clusters of small and medium-sized enterprises (SMEs).
- Facilitate public private partnerships
- Explore options for health financing of kits, including through insurance
Workplace model of HIV ST is Sustainable and Scalable

Creation of an enabling environment is key
Thank you very much

afsar@ilo.org

ILO HIV AIDS web page

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HIV SELF-TESTING AFRICA

How to deliver HIVST in a sustainable manner to increase testing coverage among priority populations

Athini Nyatela – Project coordinator HIVST (Wits RHI - Ezintsha)
WHO HIVST Guidelines recommendations

- The WHO recommends various approaches to HIV Self-Testing distribution
- These models traverse the spectrum between pure public sector service delivery to pure private sector access
- Multiple approaches to HIVST distribution have been proven to be effective across STAR countries, with many models being scaled up

Source: WHO (2016)
HIVST in Private Pharmacies
Pharmacy network across SA is extensive

<table>
<thead>
<tr>
<th>PHARMACIES</th>
<th>OUTLETS</th>
<th>SCALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clicks</td>
<td>&gt;500</td>
<td>Leading corporate pharmacy in South Africa with 500 outlets and annual turnover of more than 24 170 Rm (US$1.77 billion)</td>
</tr>
<tr>
<td>Dis-chem</td>
<td>108 + 525 independent</td>
<td>Large corporate pharmacy with 108 dischem stores and 525 independent pharmacies with annual turnover of more than 17 000 Rm (US$1.24 billion)</td>
</tr>
<tr>
<td>Alpha Pharm</td>
<td>920 community pharmacies – 420 branded</td>
<td>Alpha Pharm operates as a network of independent pharmacies, dispensaries, community pharmacies and big super stores. Private company owned by Swiss investment firm. Also serves as wholesaler and distributor.</td>
</tr>
<tr>
<td>Independent pharmacies</td>
<td>~1,100</td>
<td>Independent Community Pharmacy Association (ICPA) represents more than 1,100 pharmacies</td>
</tr>
</tbody>
</table>

Source: STAR, PSI, 2018)
>1100 Independent Community Pharmacy Members Across South Africa
How can Pharmacy help attain the 90-90-90 targets?

- A wide footprint even within rural areas;
- Extended trading hours which increases access;
- A large pool of healthcare professionals (pharmacists and nurses);
- Established logistics and supply lines;
- Advanced information systems;
- Facilities and personnel regularly inspected by SAPC;
- Strict clinical boundaries around care provision;
- Clinics offering point-of-care diagnostics and monitoring;
  - Access to Pre- and Post- test counselling by healthcare professionals
  - Access to confirmatory HIV testing
- Access to chronic medicines – dispensing or via CCMDD project
Distribution

- Provide Over-The-Counter HIVSS kits to pharmacy clients on request
- Offer to pharmacy clients seeking services indicative of HIV risk
  - HIV testing
  - PrEP / PEP request (before first fill)
  - Sexual performance enhancers
  - Lubricants
  - Condoms
  - Family Planning
  - Emergency Post-Coital Contraception
- Offer to pharmacy clients who do not know their status
Pharmacy Distribution roll out

- ICPA member requests participation in the programme.
- Pharmacy staff receive either online or face to face training by Wits RHI.
- Wits RHI allocated one peer educator per pilot pharmacy for a week to provide in-service training & support
- Pharmacies order commodities either directly from Wits RHI STAR programme or ICPA central stores
- IEC material and demand creation tools are emailed to pharmacy for printing.
- Pharmacy is activated and receives online data platform access
- Wits RHI STAR programme manages M/E and ICPA stock control
Data collection

- Unique identifier (profile number)
- Date of visit
- Date of birth
- Gender
- Previous testing history
- Cell number (if consenting)
- Consent to follow-up (1, 2 and 4 weeks post supply) with support to linkage (initials / signature)
- Test result if reported
- Linkage to care
Mobile support tools

- Several digital platforms have been developed on the STAR program to assist the end-user and to facilitate linkage into care.
  - Data free Web App that allows a patient to go through the full journey from receipt of kit, through to the process, interpretation of results and reporting.
  - A WhatsApp chat bot that allows for result reporting, testing support and troubleshooting.
  - A toll-free call in number to report results and seek additional assistance.
Demand Creation

Free HIV Self-Screening kits available here.
Test yourself for HIV today and know your status!

Have you tested recently?
Test regularly, Test anywhere

At home
Confidential, can be done anywhere

Easy
Oral swab test, no blood, results in 20 minutes

Accurate
Same test used by healthcare professionals

Available here!
<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male</th>
<th>Female</th>
<th>Other</th>
<th>Percent First time testers (Male)</th>
<th>Percent First time testers (Female)</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-19</td>
<td>18</td>
<td>58</td>
<td>1</td>
<td>56%</td>
<td>41%</td>
</tr>
<tr>
<td>20-24</td>
<td>112</td>
<td>242</td>
<td>0</td>
<td>24%</td>
<td>12%</td>
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<tr>
<td>25-29</td>
<td>197</td>
<td>354</td>
<td>1</td>
<td>19%</td>
<td>12%</td>
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<tr>
<td>30-34</td>
<td>232</td>
<td>302</td>
<td>1</td>
<td>16%</td>
<td>11%</td>
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<tr>
<td>35-39</td>
<td>212</td>
<td>212</td>
<td>2</td>
<td>11%</td>
<td>7%</td>
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<tr>
<td>40-44</td>
<td>111</td>
<td>118</td>
<td>0</td>
<td>14%</td>
<td>15%</td>
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<tr>
<td>45-49</td>
<td>76</td>
<td>39</td>
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<td>15%</td>
<td>10%</td>
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<td>50+</td>
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<td>64</td>
<td>2</td>
<td>25%</td>
<td>43%</td>
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<td>Grand Tot</td>
<td>1127</td>
<td>1440</td>
<td>7</td>
<td>17%</td>
<td>13%</td>
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</table>
Provision of HIVST through Community Based Pharmacies – Covid 19 scale up response
• Expand distribution of HIVST at pharmacies and retailers, using tools already developed on STAR.

• Pharmacies and retailers have excellent market penetration, proximity to clients, and good operational controls.

• During government-mandated lockdowns, their designation as essential services providers means that they remain almost universally accessible.

• They are therefore ideal sites to provide HIV testing, without requiring health workers or community outreach, via provision of self-testing kits.
Rapid scale-up of Pharmacy Model

- Initiated during Level 5 ("Hard lockdown") – i.e. no travel, limited logistics
- Addition of 27 new pharmacies across multiple provinces to ensure continuity of HIVST provision and services
- Utilization of national ICPA distribution infrastructure to get tests to pharmacists
- Provision of tests, job aids, IEC materials, demand creation tools
- Advertising on social media, community radio, and in-store
- Online training and pharmacy initiation
- Remote support and troubleshooting for pharmacists
<table>
<thead>
<tr>
<th>Timeframe:</th>
<th>Male</th>
<th>Female</th>
<th>Other</th>
<th>Percent First time testers (Male)</th>
<th>Percent First time testers (Female)</th>
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<td><strong>Nov 2019 – Mar 2020</strong></td>
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<td>15-19</td>
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<td>15%</td>
<td>10%</td>
</tr>
<tr>
<td>50+</td>
<td>70</td>
<td>51</td>
<td>0</td>
<td>22%</td>
<td>24%</td>
</tr>
<tr>
<td>Unknown</td>
<td>99</td>
<td>64</td>
<td>2</td>
<td>25%</td>
<td>43%</td>
</tr>
<tr>
<td>Grand Tot</td>
<td>1127</td>
<td>1440</td>
<td>7</td>
<td>17%</td>
<td>13%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Timeframe:</th>
<th>Male</th>
<th>Female</th>
<th>Other</th>
<th>Percent First time testers (Male)</th>
<th>Percent First time testers (Female)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Apr 2020 - July 2020</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-19</td>
<td>6</td>
<td>27</td>
<td></td>
<td>17%</td>
<td>20%</td>
</tr>
<tr>
<td>20-24</td>
<td>68</td>
<td>190</td>
<td></td>
<td>10%</td>
<td>6%</td>
</tr>
<tr>
<td>25-29</td>
<td>169</td>
<td>242</td>
<td></td>
<td>5%</td>
<td>2%</td>
</tr>
<tr>
<td>30-34</td>
<td>160</td>
<td>167</td>
<td></td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>35-39</td>
<td>110</td>
<td>105</td>
<td></td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>40-44</td>
<td>53</td>
<td>44</td>
<td></td>
<td>9%</td>
<td>5%</td>
</tr>
<tr>
<td>45-49</td>
<td>36</td>
<td>22</td>
<td></td>
<td>8%</td>
<td>0%</td>
</tr>
<tr>
<td>50+</td>
<td>33</td>
<td>23</td>
<td></td>
<td>5%</td>
<td>14%</td>
</tr>
<tr>
<td>Unknown</td>
<td>115</td>
<td>58</td>
<td></td>
<td>5%</td>
<td>4%</td>
</tr>
<tr>
<td>Grand Tot</td>
<td>750</td>
<td>878</td>
<td></td>
<td>5%</td>
<td>4%</td>
</tr>
</tbody>
</table>
Linkage and follow up

- Follow up is voluntary and only consenting participants can be followed.
- Positive reported cases through the mHealth channels are followed up by telephone through linkage officers.
- Confirmatory testing is recommended at the pharmacy at which the HIV Self-Test was received.
- Linkage officers provide clients with information regarding HTS services available in the area in which they live.
- Pharmacies can provide a continuum of HIV prevention and care services, including testing, ART and PrEP.
- Good opportunity for integration of SRH/FP and HIV services and products.
Acknowledgements

• UNITAID
• National Department of Health
• STAR Partners: PSI, SFH, CHAI, LSHTM
• Wits RHI Ezintsha STAR team
• WHO
• ICPA

CONTACT: MOHAMMED MAJAM, +27 82 826 0180, mmajam@wrhi.ac.za
WEBINAR
HOW TO DELIVER HIVST IN A SUSTAINABLE MANNER TO INCREASE TESTING COVERAGE AMONG PRIORITY POPULATIONS

PART 3/6: EXPERIENCES AND LESSONS LEARNED FROM STAR

Thursday, August 27 2020
9:00am EST
3:00pm UTC/GMT+2
HIV SELF-TESTING AFRICA INITIATIVE
STAR HIV Self-Testing Symposium Webinar Series

How can HIVST be integrated with HTS to strengthen screening and increase case finding offered at public sector health care facilities

Dr Thato Chidarikire, National Department of Health
Dikeledi Tsukudu, Aurum Institute, South Africa
Rationale for HIVST at health facilities

- Low testing coverage at health facilities (PITC)
- Only 10% of (eligible) clinic attendees are offered HTS
- 52% of those not offered HTS had not tested in past 12 months
- 85% of those not tested, accept when offered (25% tested HIV positive)
- Large treatment gap

- **Health system constraints**
  - Limited staff capacity
  - Time constraints for HTS
  - Counsellor workload
  - Work-space constraints
Expected Outcomes

• To increase the proportion of facility headcounts offered HIV testing.

• To increase HIV testing coverage among eligible clients accessing public sector health care facilities with high patient volumes and limited testing capacity.

• To increase the number of positive cases identified and initiated on ART.
HIVST integration into facilities in EKN over time

Number of facilities implementing HIVSS in EKN over time

- **Monthly Join**
- **Cumulative Frequency**

- **X-axis:** Months from November 2018 to November 2019
- **Y-axis:** Number of facilities implementing HIVSS
Geographic coverage: Monthly HIVST implementation in 4 districts
HIVST Outputs by sex October 2018 – June 2020
HIVST positivity rate by sex, monthly, Oct 2018 to June 2020

**Females: HIVSS Conducted and positivity, Nov 2018 - June 2020**

**Males: HIVSS Conducted and positivity, Nov 2018 - June 2020**
HIVST positivity rate by age and sex

### Females

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>HIVSS Offered</th>
<th>Reactive</th>
<th>Yield</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-14</td>
<td>1662</td>
<td>39</td>
<td>2%</td>
</tr>
<tr>
<td>15-19</td>
<td>943</td>
<td>5%</td>
<td>4%</td>
</tr>
<tr>
<td>20-24</td>
<td>1820</td>
<td>8%</td>
<td>6%</td>
</tr>
<tr>
<td>25-29</td>
<td>1546</td>
<td>10%</td>
<td>8%</td>
</tr>
<tr>
<td>30-34</td>
<td>14786</td>
<td>12%</td>
<td>10%</td>
</tr>
<tr>
<td>35-39</td>
<td>8041</td>
<td>11%</td>
<td>11%</td>
</tr>
<tr>
<td>40-44</td>
<td>1010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>45-49</td>
<td>619</td>
<td></td>
<td></td>
</tr>
<tr>
<td>50+</td>
<td>850</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Males

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>HIVSS Offered</th>
<th>Reactive</th>
<th>Yield</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-14</td>
<td>36735</td>
<td>83%</td>
<td>13%</td>
</tr>
<tr>
<td>15-19</td>
<td>36335</td>
<td>37%</td>
<td>12%</td>
</tr>
<tr>
<td>20-24</td>
<td>25142</td>
<td>14%</td>
<td>11%</td>
</tr>
<tr>
<td>25-29</td>
<td>14786</td>
<td>10%</td>
<td>8%</td>
</tr>
<tr>
<td>30-34</td>
<td>8041</td>
<td>9%</td>
<td>7%</td>
</tr>
<tr>
<td>35-39</td>
<td>1010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40-44</td>
<td>619</td>
<td></td>
<td></td>
</tr>
<tr>
<td>45-49</td>
<td>850</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **HIVSS Offered**
- **Reactive**
- **Yield**
HIVST positivity rate by date of last HIV test

**Females**
- 0 - 3 months: 40495, 3% HIVSS, 13% Reactive
- 4 - 12 months: 34004, 5% HIVSS, 6% Reactive
- > 12 months: 12572, 13% HIVSS, 6% Reactive
- Never Tested: 56709, 14% HIVSS

**Males**
- 0 - 3 months: 11829, 4% HIVSS, 5% Reactive
- 4 - 12 months: 16990, 5% HIVSS, 10% Reactive
- > 12 months: 9744, 7% HIVSS, 7% Reactive
- Never Tested: 31954, 12% HIVSS
HIVST as a proportion of total HTS in EKN

HTS_TST and HIVSS tests done in EKN

- HIVSS Implementation begins
- 50%+ of HIVSS facilities operational
- All HIVSS Facilities Operational

<table>
<thead>
<tr>
<th>Quarter</th>
<th>COP18</th>
<th>COP19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>4%</td>
<td>-</td>
</tr>
<tr>
<td>Q2</td>
<td>14%</td>
<td>-</td>
</tr>
<tr>
<td>Q3</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Q4</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Q1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Q2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Q3</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

HIVSS Implementation begins

- 50%+ of HIVSS facilities operational
- All HIVSS Facilities Operational

- COVID19

HTS: Yellow
HIVSS: Yellow
% HIVSS: Blue
Contribution of HIVST to positivity rate and new initiations

- HIVSS Implementation begins
- 50%+ of HIVSS facilities operational
- All HIVSS Facilities Operational

COVID19

- HTS_TST
- HTS_TST_POS
- TX_NEW
- Yield
HIVSS has contributed significantly to increasing the proportion of eligible headcounts tested at certain facilities in each of the Ekurhuleni sub-districts, although the impact at others is more modest. This suggests that HIVSS is not necessarily the solution in every case, but that it can have a real impact in certain facilities and situations.

<table>
<thead>
<tr>
<th>EKN East</th>
<th>Started HIVSS in...</th>
<th>% eligible HC tested (May2019)</th>
<th>% eligible HC tested (Mar2020)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP Joy Clinic</td>
<td>Nov-19</td>
<td>25%</td>
<td>71%</td>
</tr>
<tr>
<td>Gp Daveyton East Clinic</td>
<td>Apr-19</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>Gp First Avenue Clinic</td>
<td>Apr-19</td>
<td>19%</td>
<td>44%</td>
</tr>
<tr>
<td>Gp Calcot Dlephu Clinic</td>
<td>Jun-19</td>
<td>8%</td>
<td>43%</td>
</tr>
<tr>
<td>gp First Avenue Clinic</td>
<td>Aug-19</td>
<td>7%</td>
<td>42%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EKN North</th>
<th>Started HIVSS in...</th>
<th>% eligible HC tested (May2019)</th>
<th>% eligible HC tested (Mar2020)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gp Mary Moodley Clinic</td>
<td>Aug-19</td>
<td>32%</td>
<td>49%</td>
</tr>
<tr>
<td>Gp Tembisa Main Clinic</td>
<td>Mar-19</td>
<td>29%</td>
<td>44%</td>
</tr>
<tr>
<td>Gp Winnie Mandela Clinic</td>
<td>Nov-18</td>
<td>24%</td>
<td>44%</td>
</tr>
<tr>
<td>Gp Boksburg North Clinic</td>
<td>Sep-19</td>
<td>15%</td>
<td>39%</td>
</tr>
<tr>
<td>Gp Olifantsfontein Clinic</td>
<td>Feb-19</td>
<td>18%</td>
<td>39%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EKN South</th>
<th>Started HIVSS in...</th>
<th>% eligible HC tested (May2019)</th>
<th>% eligible HC tested (Mar2020)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gp Khumalo Clinic</td>
<td>Jul-19</td>
<td>11%</td>
<td>59%</td>
</tr>
<tr>
<td>GP Palmridge Clinic</td>
<td>Aug-19</td>
<td>25%</td>
<td>47%</td>
</tr>
<tr>
<td>GP Germiston City Clinic</td>
<td>Apr-19</td>
<td>27%</td>
<td>44%</td>
</tr>
<tr>
<td>GP Wannenburg Clinic</td>
<td>Apr-19</td>
<td>24%</td>
<td>40%</td>
</tr>
<tr>
<td>Gp Tamaho Clinic</td>
<td>Sep-19</td>
<td>10%</td>
<td>38%</td>
</tr>
</tbody>
</table>
### % of eligible headcounts tested, North West

- The percentage of eligible headcounts tested at these NW facilities shows a good improvement since the introduction of HIVSS, especially in Bojanala.
- This improvement is not evident in all facilities, but this data shows that for some facilities the improvement can be dramatic.

<table>
<thead>
<tr>
<th>Bojanala</th>
<th>Started HIVSS in...</th>
<th>% eligible headcount tested (May2019)</th>
<th>% eligible headcount tested (Mar2020)</th>
</tr>
</thead>
<tbody>
<tr>
<td>nw Madibeng Clinic</td>
<td>Dec-19</td>
<td>45%</td>
<td>82%</td>
</tr>
<tr>
<td>nw Mothutlong Clinic</td>
<td>Dec-19</td>
<td>28%</td>
<td>65%</td>
</tr>
<tr>
<td>nw Boitekong Clinic</td>
<td>Dec-19</td>
<td>29%</td>
<td>64%</td>
</tr>
<tr>
<td>nw Oukasie Clinic</td>
<td>Dec-19</td>
<td>11%</td>
<td>64%</td>
</tr>
<tr>
<td>nw Reagile Clinic</td>
<td>May-19</td>
<td>38%</td>
<td>63%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NMM</th>
<th>Started HIVSS in...</th>
<th>% eligible headcount tested (Dec2019)</th>
<th>% eligible headcount tested (Mar20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>nw Montshioa Stadt CHC</td>
<td>Sep-19</td>
<td>48%</td>
<td>58%</td>
</tr>
<tr>
<td>nw Ratlou CHC</td>
<td>Sep-19</td>
<td>24%</td>
<td>50%</td>
</tr>
<tr>
<td>nw Thusong Hospital</td>
<td>Feb-20</td>
<td>35%</td>
<td>48%</td>
</tr>
<tr>
<td>nw Setlagole Clinic</td>
<td>Sep-19</td>
<td>14%</td>
<td>44%</td>
</tr>
<tr>
<td>nw Lonely Park Clinic</td>
<td>Aug-19</td>
<td>29%</td>
<td>44%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DKK</th>
<th>Started HIVSS in...</th>
<th>% eligible headcount tested (Aug2019)</th>
<th>% eligible headcount tested (Mar2020)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potchefstroom Clinic</td>
<td>Dec-19</td>
<td>31%</td>
<td>53%</td>
</tr>
<tr>
<td>Tsholofelo Clinic</td>
<td>Dec-19</td>
<td>32%</td>
<td>41%</td>
</tr>
<tr>
<td>Jouberton CHC</td>
<td>Aug-19</td>
<td>32%</td>
<td>41%</td>
</tr>
<tr>
<td>Ventersdorp Gateway Clinic</td>
<td>Feb-20</td>
<td>23%</td>
<td>40%</td>
</tr>
<tr>
<td>Alabama Clinic</td>
<td>Dec-19</td>
<td>31%</td>
<td>39%</td>
</tr>
</tbody>
</table>
Case studies: Increase in case finding post HIVSS in EKN

Case finding and testing in selected EKN facilities, comparing performance pre- and post-HIVSS roll-out

- gp Andries Raditsela Clinic
- gp Ethafeni Clinic
- gp Goba Clinic
- gp Palmridge Clinic
- gp Ramokonopi CHC

% increase case finding:
- 29%
- 7%
- 6%
- 6%
- 8%

Before HIVSS | Post HIVSS implementation | % increase case finding
Conclusions

• Expected outcomes were achieved

• Requires restructuring of HTS and provision of private space for HIVST on site

• Cost-savings by HIVST: frees staff time, allows for higher client throughputs in less time, increasing testing capacity

• The programmatic and public health benefits outweigh the costs for commodity (HIVST kit cost)

• With support from government, HIVST at health facilities is easily scalable, model can be replicated in other countries, is sustainable using existing staff.

  • Scaled from 10 pilot facilities in November 2018, to 99 facilities in Ekurhuleni – Gauteng Province
  • Scaled from no facilities to 63 facilities offering HIVST within 3 months in the supported districts in North-West province
Quick Points for Participants

• Government buy-in and leadership was critical for the successful introduction of HIVST – policies, guidelines, protocols, communication and demand creation strategy, etc

• Like with any new intervention, change management was critical to manage initial resistance

• Clients are more adaptable than often assumed – irrespective of age, education level and other personal factors

• There is room for innovation as we try and manage HIV and AIDS – HIVST provides an opportunity for that
Acknowledgements

- STAR partners and sponsors
- Aurum local partners
  - PSI
  - WRHI
  - SFH
- Department of Health
  - National
  - Provincial
  - District
- National HIVST TWG
- Aurum Funders – PEPFAR; CDC
WEBINAR

HOW TO DELIVER HIVST IN A SUSTAINABLE MANNER TO INCREASE TESTING COVERAGE AMONG PRIORITY POPULATIONS

PART 3/6: EXPERIENCES AND LESSONS LEARNED FROM STAR

Thursday, August 27 2020
9:00am EST
3:00pm UTC/GMT+2

United by HIV Self-Testing Africa initiative
HIV SELF-TESTING AFRICA

Secondary Distribution of HIV Self-Testing for Partners of HIV Index and Antenatal Clinic Attendees: Uptake and Linkage to Care Results from the STAR Project in South Africa

Mohammed Majam, Head: Medical Technologies
Ezintsha, Wits RHI South Africa
Implementation of Secondary Distribution of HIV Self-Test kits by HIV Index and Antenatal Care Clients in South Africa

• This work was funded by the UNITAID grant 2017-17-SFH-STAR. The findings and conclusions in this report are those of the authors and do not necessarily represent the views of the funder.

• Vincent ZISHIRI1*, Donaldson Fadael CONSERVE2*, Zelalem T. HAILE3, Elizabeth CORBETT7, Karin HATZOLD4, Gesine MEYER-RATH5,6, Katileho MATSIMELA5, Linda SANDE7, Marc d'ELBEE7, Fern TERRIS-PRESTHOLT7, Cheryl JOHNSON8, Thatho CHIDARIKIRE9, Francois VENTER1, Mohammed MAJAM1
• Secondary distribution of HIVST kits to men through their sexual female partners is one strategy that has been employed to reach men.

• Several studies from Uganda, Kenya, and STAR Phase 1 country’s notably by Choko in Malawi have demonstrated that women/partner-delivered HIVST kits to male partners (secondary distribution) is acceptable, feasible, and effective in increasing HIV testing among men.

• The STAR program in South Africa aimed to assess the acceptability, feasibility, uptake, and cost-effectiveness of partner distribution.
Study setting

• Secondary distribution of HIVST through community health clinic attendees was done in:
  • 5 clinics in the City of Johannesburg (CoJ) district
  • 4 clinics in City of Tshwane (CoT) both in the Gauteng Province
  • 3 clinics in Dr Kenneth Kaunda (DKK) district in North West Province

• CoJ, CoT, and DKK are three of the twenty-seven priority districts
Methodology

Between April 2018 and December 2019, all clinic attendees were informed of the availability of HIVST kits that they could take home for their partners to use.

HIVST awareness talks focused on the ease, convenience and confidentially of conducting an HIVST and the need for male sexual partners of pregnant women to know their status as a prevention strategy and on how HIVST kits can be used to facilitate index testing and partner notification for their partners.

Information, education and communication materials containing quick facts and frequently asked questions about the tests were distributed to consenting participants.
## Distribution

<table>
<thead>
<tr>
<th>ANC clinic attendees</th>
<th>HIV index clients (PLWH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Up to three HIVST kits were offered for partners irrespective of HIV status of pregnant woman.</td>
<td>- HIVST were provided to all newly diagnosed HIV-positive clients or clients attending adherence clubs to take home and offer to their sexual partners who were unaware of their status.</td>
</tr>
<tr>
<td>- Targeted HIVST recipients were sexually active partners of pregnant women.</td>
<td>- The rationale for providing index clients an HIVST kit to take home for their partners was to increase access to HIV testing for sexual partners of index clients.</td>
</tr>
<tr>
<td>- HIVST kits were not offered to ANC clients if the partner was known HIV-positive or if the partner had recently tested HIV-negative.</td>
<td>- HIVST were not provided to index clients if they reported no current sexual partner or if they indicated a high risk of violence/harm.</td>
</tr>
<tr>
<td>- Trained lay counsellors screened for clients’ risk of social harm upon kit delivery.</td>
<td></td>
</tr>
<tr>
<td>- Kits were not provided to clinic attendees who indicated that the offer of HIVST may not be met well received by their partner (IPV screening).</td>
<td></td>
</tr>
</tbody>
</table>

Outcomes: uptake of HIVST by sexual partners of ANC and Index clients, positivity rate and proportions of clients with a reactive HIVST confirming their test result and initiating ART

Telephonic follow-up to ALL consenting clients at weeks 2, 4 & 6
Demographic characteristics of recipients of partner provided HIVST kits

<table>
<thead>
<tr>
<th>Distribution modality</th>
<th>ANC</th>
<th>HIV Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>District</td>
<td>COJ</td>
<td>COT</td>
</tr>
<tr>
<td>Setting</td>
<td>Urban</td>
<td>Sub-Urban</td>
</tr>
<tr>
<td>Total distributed</td>
<td>5404 (52.4%)</td>
<td>4448 (43.1%)</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- male</td>
<td>5368 (99.3%)</td>
<td>4422 (99.4%)</td>
</tr>
<tr>
<td>- female</td>
<td>36 (0.7%)</td>
<td>23 (0.5%)</td>
</tr>
<tr>
<td>- transgender</td>
<td>0 (0.0%)</td>
<td>1 (0.0%)</td>
</tr>
<tr>
<td>- undisclosed</td>
<td>0 (0.0%)</td>
<td>2 (0.0%)</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- &lt;20</td>
<td>43 (0.8%)</td>
<td>53 (1.2%)</td>
</tr>
<tr>
<td>- 20-24</td>
<td>542 (10.1%)</td>
<td>531 (12.0%)</td>
</tr>
<tr>
<td>- 25-34</td>
<td>3170 (59.0%)</td>
<td>2528 (57.2%)</td>
</tr>
<tr>
<td>- 35-44</td>
<td>1442 (26.9%)</td>
<td>1136 (25.7%)</td>
</tr>
<tr>
<td>- &gt;45</td>
<td>141 (2.6%)</td>
<td>124 (2.8%)</td>
</tr>
<tr>
<td>Unknown/missing</td>
<td>30 (0.6%)</td>
<td>50 (1.1%)</td>
</tr>
</tbody>
</table>
## Client follow-up, Partner uptake, use and entry into care

<table>
<thead>
<tr>
<th>Distribution modality</th>
<th>ANC</th>
<th>HIV Index</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CoI</td>
<td>CoT</td>
</tr>
<tr>
<td><strong>District</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total distributed</td>
<td>5368 (52.3%)</td>
<td>4422 (43.1%)</td>
</tr>
<tr>
<td><strong>Client follow-up</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consented to follow-up</td>
<td>5270 (98.2%)</td>
<td>4276 (96.7%)</td>
</tr>
<tr>
<td>Successful interview 1</td>
<td>1478 (28.0%)</td>
<td>940 (22.0%)</td>
</tr>
<tr>
<td>Successful interview 2</td>
<td>479 (9.1%)</td>
<td>373 (8.7%)</td>
</tr>
<tr>
<td>Successful interview 3</td>
<td>490 (9.3%)</td>
<td>381 (8.9%)</td>
</tr>
<tr>
<td>Days to 1&lt;sup&gt;st&lt;/sup&gt; interview</td>
<td>16 (16.0)</td>
<td>17 (13.0)</td>
</tr>
<tr>
<td>Days to 2&lt;sup&gt;nd&lt;/sup&gt; interview</td>
<td>33 (42.0)</td>
<td>39 (37.0)</td>
</tr>
<tr>
<td>Days to 3&lt;sup&gt;rd&lt;/sup&gt; interview</td>
<td>9 (33.0)</td>
<td>21.5 (60.0)</td>
</tr>
<tr>
<td><strong>Total successfully followed up</strong></td>
<td>2461 (46.4%)</td>
<td>1702 (39.6%)</td>
</tr>
<tr>
<td><strong>Partner uptake &amp; use</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Offered partner kit</td>
<td>2098 (85.2%)</td>
<td>1320 (77.6%)</td>
</tr>
<tr>
<td>Partner took kit</td>
<td>2047 (97.6%)</td>
<td>1311 (99.3%)</td>
</tr>
<tr>
<td>Partner used kit</td>
<td>1995 (97.5%)</td>
<td>1285 (98.0%)</td>
</tr>
<tr>
<td><strong>Entry into Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIVST Reactive result</td>
<td>105 (5.3%)</td>
<td>52 (4.1%)</td>
</tr>
<tr>
<td>Attended confirmatory testing</td>
<td>85 (81.0%)</td>
<td>40 (76.9%)</td>
</tr>
<tr>
<td>Confirmed HIV+</td>
<td>80 (94.1%)</td>
<td>34 (85.0)</td>
</tr>
<tr>
<td>Initiated on ART</td>
<td>79 (98.8%)</td>
<td>34 (100.0%)</td>
</tr>
</tbody>
</table>
Results

Secondary Distribution

Partners of PLWH

29% (4154/14473)

3269 (78.7%) went to male partners

Partners of ANC Attendees

71% (10319/14473)

10256 (99.4%) went to male partners

Of the 4066 (97.9%) Index clients who consented to follow-up across the three districts, 1649 (40.6%) were successfully followed up

10135 (98.2%) ANC clients who consented to telephonic follow-up across the three districts, 4235 (41.8%) were successfully followed up
Summary of outcomes

ANC:
- 82.1% offered
- 98.1% accepted
- 97.6% report use
- 4.8% reported +ve

Index:
- 79.6% offered
- 95.8% accepted
- 95.9% report use
- 24.6 reported +ve
Costing

• The average cost per HIVST kit distributed via ANC clients and Index varied across all districts.
  • In COJ, the average cost per kit distributed was US$13.33 through ANC clients compared to US$10.36 in Index clients.
  • A similar variation was observed in DKK with the average cost per kit distributed amounting to US$6.61 and US$17.02 for ANC and Index, respectively.
  • In COT, however, the average cost per kit distributed was comparable at US$15.17 and US$14.55 for ANC and Index clients, respectively.
Discussion

• Similar to findings from STAR projects targeting men in three other African countries, both ANC and HIV index HIVST distribution modalities reached men successfully (> 99% of kits distributed via ANC clinic attendees and >75% of kits distributed via HIV index clients went to men).

• Given the known poor clinic attendance, behaviors of men; this implementation describes and demonstrates practicality of innovative approaches of reaching men with HIV testing using partner-provided HIVST.
Discussion...cont

• There was a high uptake after offer and reported use of HIVST delivered by partners of ANC clients

• ANC and Index clients reported a high proportion of their newly HIV diagnosed partners (>85%) entering into care early after HIVST were delivered to their partners across both models.

• The cost of facility-based HIVST distribution was highly variable between the three districts

• Average cost per kit distributed in CoJ and CoT is comparable to facility based HIVST distribution costs reported in other studies of similar settings.

• Largest cost drivers for distributing the kits from a provider perspective was human resource across both distribution modalities and all three districts.
Conclusions

- Partner delivered self-testing was highly acceptable
- High proportions of HIV positive partners identified entering into care.
- HIV index testing delivered a high yield
- Intensifying follow-up can provide for more conclusive evidence on utilization of kits.

- Limitations of the study:
  - Low distribution numbers and distribution period in DKK
  - Self-report bias
  - Follow up rate
Acknowledgements

- Unitaid
- National Department of Health
- STAR Partners: PSI, SFH, CHAI, LSHTM
- Wits RHI Ezintsha STAR team
- WHO

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WEBINAR

HOW TO DELIVER HIVST IN A SUSTAINABLE MANNER TO INCREASE TESTING COVERAGE AMONG PRIORITY POPULATIONS

PART 3/6: EXPERIENCES AND LESSONS LEARNED FROM STAR

Thursday, August 27 2020
9:00am EST
3:00pm UTC/GMT+2